North Carolina Division of Medical Assistance (DMA)
PERSONAL CARE SERVICES-PLUS (PCS-PLUS) REQUEST FORM

1. ☐ **PCS-Plus Initial Request** ☐ **PCS-Plus Reauthorization Request**

Date of Request: _____ Request Submitted by: _____
Total Number of PCS Hours/Month Requested: _____ **hours/month**
Duration of PCS-Plus Request*: _____ **days** From: _____ To: _____
**PCS-Plus authorizations cannot exceed 180 days. To request an extension, submit a new PCS-Plus Request Form at least one week before the PCS-Plus authorization expires.*

DMA Prior Approval
Authorization for _____ hours/month*
**Cannot exceed a total of 80 hours/month.*
Effective from: _____ to: _____
Date Request Reviewed: _____
RN Signature: _____

2. **Provider Agency Information**

Agency Name: _____ PCS Provider #: _____ Phone: _____ Fax: _____
Address: _____ Email: _____

3. **Medicaid Recipient Information**

Last Name: _____ First Name: _____ Middle Name: _____
Address: _____ County: _____
Phone Number: _____ Medicaid ID # (MID): _____ Date of Birth: _____
Currently on PCS? ☐ Yes ☐ No**If no, agency RN must follow DMA procedures for PCS assessment and obtaining MD approval.*
Physician Name: _____ Phone Number: _____ Date DMA-3000 Signed: _____

4. **Specify Primary and Secondary Diagnosis:** _____

If a medical or cognitive condition is being used to qualify for PCS-Plus, the assessment must document at least one of the following (check all that apply):

- ☐ Presence of continuous and/or substantial pain interfering with individual's activity or movement
- ☐ Dyspneic or noticeably short of breath with minimal exertion during ADL performance and requires continuous use of oxygen
- ☐ Due to cognitive functioning, individual requires extensive assistance with performing ADLs. Individual is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ Bowel incontinence more often than once daily ☐ Urinary incontinence during the day and night ☐ Not Applicable

5. **List Current Medications (include medication name, dose, frequency, and route of administration)**

6. **Limitations in Activities of Daily Living (ADLs)**

Rate the individual's ADL Self-Performance and ADL Support Provided using the scores below

A. ADL Self-Performance Scores

0. INDEPENDENT: No help or oversight needed.
1. SUPERVISION: Oversight, encouragement or cueing needed.
2. LIMITED ASSISTANCE: Individual highly involved in activity; receives help in guided maneuvering of limbs or other non-weight bearing assistance.
3. EXTENSIVE ASSISTANCE: While individual performs part of activity, help of the following is needed: *weight-bearing support OR substantial or consistent hands-on assistance with eating, toileting, bathing, dressing, personal hygiene, or self-monitoring of meds.*
4. FULL DEPENDENCE: Full performance of activity by another.

B. ADL Support Provided Scores

0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+persons physical assist

			ADL Self-Performance	ADL Support Provided
a	**Bed Mobility**	Moving to and from lying position, turning side-to-side and position body while in bed.		
b	**Transfer**	Moving to and between surfaces: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet)		
c	**Ambulation**	Note assistive equip. (walker, wheelchair, hoyer lift); self-sufficiency once in chair. **Assistive Equip:** _____		
d	**Eating**	Taking in food by any method, including tube feedings. **Therapeutic Diet:** _____		
e	**Toilet Use**	Using the toilet (commode, bedpan, urinal); transferring on/off toilet, cleaning self after toilet use, changing pads/diapers, managing any special devise required (ostomy or catheter), and adjusting clothes.		
f	**Bathing**	Taking full-body bath/shower, sponge bath, transferring in/out of tub/shower. (Exclude washing back/hair)		
g	**Dressing**	Laying out clothes, retrieving clothes from closet, putting clothes on and taking clothes off.		
h	**Personal Hygiene**	Combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, and perineum. (Exclude baths and showers)		
i	**Self-Monitoring**	Self-monitoring of pre-poured medications, glucometers, etc.		

7. **Nurse Aide II Tasks (specify task and frequency below)**

8. **Nurse Assessor Certification**

I certify that the above information reflects this Medicaid recipient's condition and that the recipient's DMA-3000 was signed by the attending physician on (specify date) _____ to obtain authorization for PCS.
Print Name: _____ Signature: _____ Date: _____